Salzano Eye Center, LLC

Eyecare Registration and History Form

526 Bloomfield Avenue. Suite 203, Caldwell, NJ 07006

1

Patient Information

Date: _____

Patient:_____

Address: _____

_____

City:_____

State:_____Zip:_____

Sex: ☐ M ☐ F Age:_____DOB: _____

☐ Single ☐ Married ☐ Widowed

☐ Separated ☐ Divorced

Patient SS#:_____

Occupation:_____

Employer:_____

Location:_____

Name of Primary Doctor_____

Phone:_____

Town:_____

Pharmacy:_____

Phone:_____

Town:_____

2

Insurance

Primary Insurance:_____

Subscriber:_____

Relationship to Patient: _____

Subscriber DOB:_____

Secondary Insurance:_____

Subscriber:_____

Do you need a referral to see Dr. Salzano? ☐ Yes ☐ No

Vision Plan: ☐ Yes ☐ No

Name of Plan:_____

Member's Name:_____

Member's DOB:_____

Last 4 digits of SS#:_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with

_____and assigned directly to Dr. Salzano all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:

_____

Relationship:_____Date: _____

Vision Plans are for routine exams ONLY! Medical Plans are for problems, follow-up or testing visits.

3

Contact Information

Home:_____Cell:_____Work:_____Email:_____

HIPAA PRIVACY AUTHORIZATION

Please list the names and relationships of the people with whom we can discuss your medical issues:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

4

Eye Health History

Reason For Today's Visit: ☐Routine ☐Problem

Date of Last Exam:_____

Do you wear glasses: ☐Yes ☐No

☐All the time ☐Driving ☐ Reading

Do you wear contacts: ☐ Yes ☐ No

Brand:_____

Base Curve: _____

(Right Eye) Power:_____ Sphere:_____ Cylinder:_____ Axis:_____ ADD:_____

(Left Eye) Power:_____ Sphere:_____ Cylinder:_____ Axis:_____ ADD:_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following.

Bloodshot Eyes	☐Yes	☐ No	Glaucoma	☐Yes	☐ No
Blurred Vision- Distance	☐Yes	☐ No	Headaches	☐Yes	☐ No
Blurred Vision - Near	☐Yes	☐ No	Itching Eyes	☐Yes	☐ No
Burning Eyes	☐Yes	☐ No	Light Sensitive	☐Yes	☐ No
Cataracts	☐Yes	☐ No	Loss of Vision	☐Yes	☐ No
Color Vision Poor	☐Yes	☐ No	Macular Degeneration	☐Yes	☐ No
Crossed Eyes/Strabismus	☐Yes	☐ No	Migraine Headaches	☐Yes	☐ No
Discharge from Eyes	☐Yes	☐ No	Night Vision Poor	☐Yes	☐ No
Dizzy Spells	☐Yes	☐ No	Red Eyes	☐Yes	☐ No
Double Vision	☐Yes	☐ No	Retinal Disease	☐Yes	☐ No
Dry Eyes	☐Yes	☐ No	Seeing Halos	☐Yes	☐ No
Eye Infection	☐Yes	☐ No	Seeing Flashes	☐Yes	☐ No
Eye Injury	☐Yes	☐ No	Temporary Loss of Vision	☐Yes	☐ No
Eye Strain	☐Yes	☐ No	Twitching Eyelid	☐Yes	☐ No
Eye Surgery	☐Yes	☐ No	Vision Poor	☐Yes	☐ No
Fainting Spells, Blackouts	☐Yes	☐ No	Watering Eyes	☐Yes	☐ No
Floaters or Spots	☐Yes	☐ No			

Family Eye History: Check all that apply

☐Cataracts ☐Glaucoma ☐Macular Degeneration ☐Retinal Disease

5

Medications

List the medications you are currently taking, including eye drops:

_____

_____

_____

_____

_____

_____

_____

Allergies

List your allergies to medications or other

_____

_____

_____

_____

_____

_____

_____

6

Consent to Use Dilating Drops

Dilating eye drops are used to enlarge the pupils, allowing Dr. Salzano to examine the inside of your eye. For many types of eye examinations, this is usually a requirement.

Dilating drops will usually cause blurred vision. Bright sunlight also can make it difficult to see. The length of time that your vision will be blurred, and the degree to which your eyesight is impaired, varies from patient to patient. Therefore, we strongly suggest you make arrangements for transportation. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself and others. In addition, adverse reactions, such as acute angle-closure glaucoma, may be triggered from the use of dilating drops. This is extremely rare and treatable with immediate medical attention.

Print Name:_____ Signature:_____ Date:_____

Health History

Physician's Name:_____Date of last visit:_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following.

AIDS/HIV	☐ Yes	☐ No	Hepatitis (Type____)	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Drug Sensitivity	☐ Yes	☐ No	Skin Conditions	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Thyroid Conditions	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No			

If under 18

Birth History: #Weeks_____Complications_____ Tobacco use:_____ Alcohol Use:_____

Medicare Authorization

ATTENTION ALL MEDICARE PATIENTS

Medicare will **NOT** cover the cost of the **REFRACTION.**

*The refraction is the part of the part of the exam that determines your prescription for either glasses or contacts.

We do submit to secondary insurance however, we do not know how much they will cover, if any.

The most this service will cost you is **$45**.

I understand that Medicare will not cover the cost of the refraction. I agree to be personally and fully responsible for payment. That is, I will pay personally either out of pocket or through any other insurance I have.

Check One:

Yes ☐ I want receive these items or services.

No ☐ I have decided not to receive these items or services.

Date:_____ Signature:_____